

Welmede Housing Association Limited

Palmer Crescent

Inspection report

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Date of inspection visit:
09 March 2018

Date of publication:
02 July 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Palmer Crescent is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Palmer Crescent accommodates up to 24 people in four bungalows on one site, each of which has separate adapted facilities. The registered provider of the service is Welmede Housing Association Limited, part of the Avenues Group, which specialises in providing care to people with learning disabilities or autism.

There was no registered manager in place at the time of our inspection. The previous registered manager had left their post at the beginning of February 2018. A new manager had been appointed and was due to take up their post the week after our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider's cluster manager told us the new manager would apply for registration with CQC.

We found there was an over-reliance on agency staff which affected people's experience of care. There was a high number of vacancies on the permanent staff across the four bungalows. The provider had maintained the staffing levels needed to keep people safe but the high use of agency staff meant people were often supported by staff who did not know them well. Relatives told us that it was important for their family members' well-being to be supported by familiar staff who knew their needs well. They said the high use of agency staff was discomfiting for their family members. The high number of vacancies also placed pressure on the remaining permanent staff. They were working hard to ensure people received the care they needed but some staff were working excessive hours.

Shortages of permanent staff also affected people's opportunities to take part in activities. There were not enough authorised drivers employed to take people to some of their planned activities and staff had to prioritise taking people to medical appointments. This meant that some people's identified needs were not being met.

Following our inspection the provider's regional manager acted promptly to develop an action plan to address the concerns we had identified. This plan set out how the consistency of care people received would be improved and how permanent staff would be supported. Actions included allocating experienced staff from elsewhere in the organisation to support the service until new permanent staff could be recruited and block-booking agency staff to ensure that regular agency staff were employed.

Risks to people's safety were identified and action taken to keep people as safe as possible. Accidents and incidents were reviewed and measures implemented to reduce the risk of them happening again. Health and safety and fire safety checks were carried out regularly to ensure the home was safe and well

maintained. The provider had developed a contingency plan to ensure that people's care would continue in the event of an emergency. The bungalows were suitably adapted and designed to meet people's needs. Adaptations and equipment had been installed where necessary to ensure people were able to mobilise safely.

Staff were recruited safely. The provider obtained evidence from agencies that the temporary staff supplied had undergone appropriate pre-employment checks. Staff understood their responsibilities in safeguarding people from abuse and knew how to report any concerns they had. People received their medicines safely and as prescribed. Staff maintained appropriate standards of hygiene and cleanliness and followed safe infection control procedures.

People's needs had been assessed before they moved into the home to ensure staff could provide the support they required. Staff had the training and support they needed to carry out their roles effectively. Staff attended an induction when they started work and had access to ongoing training. Specific training was provided if people developed needs that required it. The provider checked that agency staff had attended training relevant to the roles they performed.

People's rights under the Mental Capacity Act 2005 were respected. Staff understood the importance of gaining people's consent to their care and how people communicated their decisions. People who lacked capacity received appropriate support when decisions that affected them were made. Applications for DoLS authorisations had been submitted where restrictions were imposed upon people to keep them safe,

People were able to make choices about the food they ate and were supported to maintain a healthy diet. Staff ensured that individual support guidelines around diet and nutrition were followed. People were supported to maintain good health and to obtain treatment when they needed it. Each person had a health action plan which detailed their health needs and the support they needed.

Staff treated people with respect and maintained their dignity. They respected people's individual rights and promoted their independence. People were supported to make choices about their care and to maintain relationships with their friends and families.

Care plans had been developed where needs had been identified during assessment. These were personalised and provided guidance for staff about how care should be delivered. They also outlined what people could do for themselves and how staff could support them to be independent. The provider had established people's preferences about their end of life care to ensure their wishes would be respected should they become seriously ill.

There were appropriate procedures for managing complaints. Relatives told us that any concerns they had raised had been listened to and acted upon by the provider. Checks on the management of were included in The provider's quality monitoring audits checked that any complaints received an appropriate response.

Relatives told us the provider communicated openly with them. They said the previous registered manager had always been available if they wished to discuss their family member's care with them. Relatives told us the regional manager had listened to their concerns about the high use of agency staff and how this affected their family members. They said the regional manager had made them aware of the plans in place to address this issue.

People who lived at the home, their relatives and other stakeholders had opportunities to give their views about the service. The provider's quality monitoring systems included auditing important areas of the

service regularly and action plans were developed when shortfalls were identified.

We identified two breaches of the Health and Social Care Act 2008. Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

There were not enough staff with appropriate knowledge and skills deployed to meet people's needs.

People were supported to take manageable risks as safely as possible.

Staff understood their roles in keeping people safe.

People would continue to receive care in the event of an emergency.

People were protected by the provider's recruitment procedures.

Medicines were managed safely.

People were protected from the risk of infection.

Requires Improvement ●

Is the service effective?

The service was effective.

People's needs had been assessed before they moved into the home to ensure their needs could be met.

Staff had access to the support, supervision and training they needed to support people effectively.

People's care was provided in line with the Mental Capacity Act 2005 (MCA).

People were encouraged to maintain a healthy diet and staff were aware of people's individual dietary needs.

People's healthcare needs were monitored and they were supported to obtain treatment when they needed it.

The physical environment of the home met people's needs and equipment and adaptations were in place where necessary.

Good ●

Is the service caring?

The service was not consistently caring.

People's experience of care was affected by a lack of consistency in staffing.

Staff treated people with respect and maintained their privacy and dignity.

Staff respected people's choices about their care and support

People were supported to maintain relationships with their friends and families.

Staff supported people in a way that promoted their independence.

Requires Improvement ●

Is the service responsive?

The service was not consistently responsive to people's needs.

People did not have enough opportunities to take part in activities.

Care plans had been developed where needs had been identified through the assessment process.

There were appropriate procedures for managing and responding to complaints.

The provider had established people's preferences about their end of life care.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

The provider had not mitigated the risks to people and staff until these were highlighted in feedback following the inspection.

Relatives told us the provider communicated openly with them.

Staff were able to give their views at team meetings and said the previous registered manager was supportive.

The provider sought the views of all stakeholders through annual surveys.

Requires Improvement ●

Staff worked well in partnership with other agencies to ensure people received the care and support they needed

The provider's quality monitoring systems ensured key aspects of the service were regularly audited.

Palmer Crescent

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 March 2018 and was unannounced. This was a comprehensive inspection carried out by two inspectors.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We also reviewed information from other relevant agencies, such as the local authority quality monitoring team. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we met five people who lived at the service and six members of staff. We also spoke with a cluster manager employed by the provider who attended to support the inspection. If people were unable to tell us directly about their experience due to their communication needs, we observed the care they received and the interactions they had with staff. We looked at six people's care records, including their assessments, care plans and risk assessments. We checked records of recruitment, training and supervision. We also looked at health and safety checks, quality monitoring checks and how medicines were managed.

After the inspection we spoke with two relatives to hear their views about the care their family members received. We also reviewed the action plan sent to us by the provider following the inspection.

Is the service safe?

Our findings

There were not enough staff with appropriate knowledge and skills deployed to meet people's needs. The permanent staff team had been depleted by recent resignations and there was a high number of vacancies across the four bungalows. The provider had made sure the staffing levels needed to keep people safe were maintained but vacancies on the permanent team meant that there was a heavy reliance on agency staff.

Relatives highlighted permanent staff leaving and the high use of agency staff as a concern. One relative told us, "We have lost five core staff and they haven't been replaced. We have lost staff who had lots of experience and knew people well. We have also lost the team leader." The local authority had also identified the issue of staff leaving as a concern at their last visit to the service. The report of the local authority's visit stated, 'The residents are safe and cared for but staff morale is low and this may be impacting on the support provided and the overall customer experience.'

Permanent staff confirmed that agency staff were used on most shifts to maintain safe staffing levels. One permanent member of staff told us, "We have enough staff but only because we use agency. We use it every day, sometimes more than one. It's the same for all the bungalows." Permanent staff said the quality of agency staff was variable, which meant people did not receive consistent care. One member of staff told us, "We are relying on agency staff. Some are good, some are not so good. One refused to work in another bungalow this morning." Another permanent member of staff said, "The two [agency staff] here today are good, they are experienced, I know I can trust them but we [permanent staff] are under pressure to make sure everyone is safe and things are done properly."

The permanent staff we spoke with told us the high use of agency staff placed additional demands on them as well as affecting the support people received. One permanent member of staff said, "It affects us [permanent staff] a lot. It is stressful. If we work with agency [staff], we know we have to do most of the work. When new people come in, it takes time to show them what to do, to orientate them." Another permanent member of staff told us, "We are short of permanent staff. The last few months it's been difficult. A lot of staff have left." Relatives said permanent staff were providing good care to their family members in challenging circumstances. One relative told us, "I wouldn't criticise the permanent staff, they are good, capable people, but they are doing too many shifts." Another relative said of permanent staff, "They work wonders considering the pressure they are under."

Permanent staff were working hard to ensure people received the care they needed but were being placed under pressure by the demands placed upon them. Some permanent staff were working excessive hours to ensure that a member of experienced staff who knew people well was always on duty. One permanent member of staff told us, "I'm contracted to do 35 hours a week but sometimes I am doing 70, 80 hours a week." One member of permanent staff on duty during our inspection had started work at 7.00am the previous day and worked until 10.00pm. The member of staff had then done the sleep-in duty, during which they got up at 2.30am to support a person. The member of staff had not been back to sleep before starting their next shift at 6.00am and worked until 2.00pm on the day of our inspection. Another member of permanent staff had worked from 2.00pm until 10.00pm the previous day and was working a 6.00am until

2.00pm shift on the day of our inspection. The member of staff told us that they had been due to do the sleep-in shift the previous night but the agency staff assigned to the waking night shift had not arrived, which meant they had to cover this shift. The excessive hours worked by some staff meant their performance, and thus the care people received, could be adversely affected.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008.

Risks to people's safety had been assessed and measures put in place to keep people safe while enabling positive risk-taking. The provider's PIR stated, "We support people to manage the risks involved in exercising control over their own lives through offering guidance or best interest process." Risk assessments had been carried out in relation to moving and handling, falls, nutrition and hydration and any areas specific to people's needs. For example one person was at risk of ingesting non-food items. Measures had been implemented and staff had guidance to follow to ensure the person did not have access to non-food items. Another person had an alarm under their mattress which alerted staff if the person got out of bed during the night. A best interests process had been followed to ensure the person's safety and rights had been considered when this decision was made. People at risk of choking were protected because staff followed guidance from healthcare professionals to minimise this risk. A missing person profile had been created for each person which staff would share with the police should a person go missing.

Staff carried out regular checks to ensure the environment was safe. This included weekly checks of firefighting equipment, escape routes and emergency lighting. Staff also checked the fire alarm system every week using different call points. There was a fire risk assessment for the service and personal emergency evacuation plans had been developed which identified the support people would need in an emergency. The provider had a business continuity plan which detailed plans to ensure people would continue to receive care in the event of an emergency. The provider's health and safety manager carried out regular audits to ensure certificates of gas, electrical, fire and water safety were up to date.

There was evidence of learning when adverse events occurred. Accidents and incidents were recorded in detail and had been reviewed by the manager to identify any measures that could reduce the risk of a recurrence. Risk assessments and support plans were also reviewed where appropriate to ensure guidance for staff was up to date. Accident and incident records were checked in audits carried out by the provider to ensure appropriate action had been taken following adverse events. The provider's PIR stated, 'When accidents or incidents occur we review and make adjustments to risk assessments or practice, findings are shared across the team. The SMT [senior management team] also review all accidents/ incidents across the whole organisation at a weekly safeguarding meeting.' Staff attended training in a range of areas designed to help them provide safe care. The provider's PIR stated, 'Training includes First Aid, fire safety, manual handling, COSHH, infection control, safeguarding adults, care and control of medicines and risk management.' We found evidence to support the provider's statement.

The provider carried out checks before staff began work to ensure they were suitable for their roles. These checks include proof of identity, proof of address, references and a Disclosure and Barring Service (DBS) certificate. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. We saw evidence that staff had attended an interview which had explored their experience and suitability for the role. To ensure that agency staff had been recruited safely, the provider received confirmation from the agencies that these checks carried out on the staff they supplied.

Staff understood their roles in keeping people safe and their responsibility to report any concerns they had.

They told us they would not hesitate to raise concerns about abuse or people's safety or abuse with their managers and knew how to report concerns with external agencies if necessary. The PIR set out how the provider ensured a focus on reporting concerns was maintained. The PIR stated, "A new section on the supervision template has been added focusing on whistle-blowing and concerns. Safety is discussed at each supervision and team meetings, audits and checklists are completed and robust policies are in place to safeguard from abuse and the risk of harm." Staff confirmed that they were asked at supervisions and team meetings whether they had any concerns about abuse or poor practice. When people had voiced concerns about the care they received, the provider had responded appropriately to investigate the issues raised. For example, when one person made a complaint about the care they had received in 2017, the provider suspended the member of staff about whom the complaint had been made whilst an investigation was carried out. The provider also notified the CQC and referred the complaint to the local safeguarding team.

People's medicines were managed safely. Medicines were stored, administered and recorded appropriately. Staff who administered medicines had to demonstrate their competency in an observed assessment before being authorised to do so. The provider had appropriate medicines management procedures and staff followed these to ensure people received their medicines as prescribed. There were appropriate arrangements for the ordering and disposal of medicines and guidelines regarding medicines prescribed 'as required' (PRN). Staff carried out regular medicines audits and medicines management systems were also checked periodically by the supplying pharmacist.

Staff maintained appropriate standards of hygiene which protected people from the risk of infection. The bungalows were cleaned regularly to maintain hygiene and reduce the risk of infection. People's support plans contained individual risk assessments in relation to infection control. Staff followed good practice in infection control and used personal protective equipment, such as gloves and aprons, when providing personal care. The provider had infection control procedures for staff to follow and carried out regular audits to check appropriate standards of infection control were being maintained.

Is the service effective?

Our findings

People's needs had been assessed before they moved into the service to ensure staff could provide the care they required. Staff were provided with training to develop the skills they needed to provide safe and appropriate care. All staff had an induction when they started work which the PIR said included, 'Shadowing days in the service supported by a buddy who will mentor and supports the new starter. The Care Certificate is completed as part of their induction.' The Care Certificate is a set of nationally agreed standards that health and social care workers should demonstrate in their daily working lives.

Following their induction staff had regular refresher training in core areas. Staff also attended training in areas relevant to the needs of the people they cared for, such as autism, epilepsy and dementia. Staff told us that the quality of training provided was good and that they were expected to keep up to date in all areas of mandatory training. One member of staff said, "I am up to date with all my training. The training is really good here, it always has been." Staff also told us that they received one-to-one supervision from their managers. They said this gave them opportunities to discuss their performance and training needs. The staff files we checked confirmed that staff received supervision on a regular basis.

Relatives told us their family members enjoyed the food provided. They said staff encouraged their family members to maintain a healthy diet whilst enabling them to choose foods they enjoyed. One relative told us their family member had specific dietary requirements and that staff followed professional guidance to ensure these needs were met. The PIR stated that, 'Staff promote and encourage service users to eat a well-balanced diet. All service users contribute to the weekly menu planning. Service users have input with online food shopping. The service caters for specific diets such as diabetes, allergies or intolerances. We will offer different meal choices to cater for everyone's preferences.' We observed during our inspection that staff offered people choices at mealtimes and supported them to have drinks and snacks of their choice throughout the day. Staff also provided one-to-one support to people who required assistance to eat and drink.

People were supported to stay healthy and to obtain treatment if they needed it. Care records demonstrated that people's healthcare needs were monitored by staff and that people were supported to obtain treatment if they needed it. There was a health action plan for each person which recorded their medical history, health needs and any treatment they received for ongoing conditions. Each person had a care passport, which provided important information for medical staff in the event of a hospital admission. This was particularly important for one person who had been identified as needing additional support should they be admitted to hospital.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights under the MCA were respected. Staff understood that they should assume people had the capacity to make decisions unless an assessment had proved otherwise. Capacity assessments had been carried out where necessary to determine whether people needed support when decisions that affected them were being made. For example, an assessment had been carried out to determine whether a person had capacity to consent to the installation of an alarm underneath their mattress. Where people lacked the capacity to make a particular decision, staff had consulted all relevant people, such as relatives and healthcare professionals, to ensure the decision was made in the person's best interests. Staff understood that any measures which restricted people's individual choices for their own safety should only be imposed where authorised and should be as least restrictive as possible. The provider had submitted applications for DoLS authorisations to the local authority where people were subject to restrictions in their care.

The bungalows were suitably adapted and designed to meet people's needs. Each bungalow had a communal lounge, dining area, kitchen and bathrooms. The communal rooms were comfortable and homely and well used by people during our inspection. Each person had their own bedroom which they were encouraged to personalise according to their individual tastes and interests. Adaptations and equipment had been installed where necessary to ensure people were able to mobilise safely around their home. There was evidence that all equipment involved in people's care, such as wheelchairs and hoists, was serviced regularly to ensure it was safe for use.

Is the service caring?

Our findings

People's experience of care was affected by a lack of consistency in staffing. Relatives told us that permanent staff knew their family members well and understood how to support them in the way they preferred. They said the lack of consistency caused by the high use of agency staff meant their family members were often supported by staff who did not know them well. One relative told us, "The permanent staff understand her but there are too many of these agency staff. They don't know them [people] well enough." The relative said, "If new staff come in that [family member] doesn't know, it disrupts her a little bit." Another relative said the high use of agency staff affected their family member's experience of care because, "[Family member] has particular needs that are better met by staff who know him." A member of permanent staff told us, "We have some people here who don't like seeing new faces all the time."

We observed during our inspection that permanent staff knew the people they cared for well and engaged with them in a positive way. Permanent staff initiated conversations with people and joined them in impromptu activities. Some of the agency staff on duty were not proactive in their interactions with people and did not seek to engage them in conversation or activities.

The action plan submitted by the provider's regional manager after the inspection set out how the consistency of care people received would be improved. The measures put in place included recruiting new permanent staff and allocating existing permanent staff to a particular bungalow for a minimum of six months until new staff had been recruited and inducted to their roles. The plan also included allocating experienced staff from elsewhere in the organisation to support the service and booking agency staff for blocks of three months to ensure that regular agency staff were employed.

We recommend that the provider monitor the implementation of the action plan to ensure that people receive consistent care from regular staff who understand their individual needs and preferences.

People's privacy and dignity was respected. Relatives told us staff treated their family members with respect and maintained their dignity. They said personal care was always provided in private and that their family members could have privacy when they wanted it. Staff attended equality and diversity training in their induction and the staff we spoke with understood the importance of ensuring people's human rights were upheld. People were supported to maintain relationships with their friends and families. Relatives told us that they could visit whenever they wished and that they were made welcome when they visited.

Relatives told us that staff respected their family members' choices about their care and support. The provider's PIR stated, 'We always ensure choice, control and involvement is key to the individual.' Staff used different methods of communication to ensure information was presented to people in ways they understood, which helped them make choices and decisions. For example staff used photographs, symbols or objects of reference to give people as much information as they could.

Staff promoted people's independence. We observed that staff provided support when people needed it but encouraged them to manage their support independently where possible. People's care plans set out what

they could do for themselves and how staff should support them to achieve this. The last local authority monitoring visit had focused on how staff enabled people to be independent and to be involved in the life of the home. The report of the local authority's visit stated, 'Staff use picture cards to support the residents to make menu choices. Staff support the residents to be as independent as possible and let them choose the clothes they would like to wear and will offer baths and showers. One of the residents likes to lay the table at meal times and help clear up after the meal. One resident will take her dirty plate to the sink after a meal and another resident will support with putting clean laundry away.'

Is the service responsive?

Our findings

People did not have sufficient opportunities to take part in meaningful activities. Work had been carried out to plan activities that people enjoyed but these frequently did not take place. Relatives and staff reported that a major factor affecting activities was the lack of drivers on the staff team. They told us the number of permanent staff who had left had reduced the number of staff authorised to drive the home's allocated vehicles. One relative said of their family member, "She doesn't do half as much as she used to. It would be nice if they could go out in the minibus but the trouble is they haven't got the drivers."

Staff confirmed that people's opportunities to participate in activities were restricted by the lack of authorised drivers. One member of staff told us, "We would like to get people out more but we are short on drivers." Another member of staff said of the opportunities for activities, "It's a problem. Some of the staff who left were drivers. We used to do a lot of activities that we don't do any longer." A third member of staff told us, "Sometimes recently we are short of drivers so the trips don't always happen." Staff told us that they had to prioritise people's medical appointments over activities provision. One member of staff said, "Sometimes they miss out. Appointments at the hospital or the doctor's are the priority." This occurred on the day of our inspection. One person was scheduled to attend a resource centre but was unable to do so because another person had a medical appointment and there were insufficient drivers available to enable both trips. Feedback from the most recent local authority quality monitoring visit to the service stated, 'Staff informed me that residents currently do not get out on weekends due to staff shortages. When this happens staff are moved around the homes in the cluster to ensure residents are kept safe and this takes priority over activities out.'

The lack of opportunities to go out and engage in activities meant that some people's identified needs were not being met. Some people's care plans recorded that being active and going out was an important part of meeting their needs. For example staff had recorded on one person's care plan that a 'Good day' would include 'Going out' and that a 'Bad day' would be represented by 'Not being able to go out and about. Unfamiliar people supporting me.' The person sometimes displayed behaviour that challenged the service. The person's support plan stated that they 'Like to be occupied' and that the person was more likely to display these behaviours when they were bored. We observed that no planned activities for this person took place during our inspection and that the person did display behaviours that challenged the service. A review of this person's support plan in February 2018 recorded under 'Not so good things', '[Person] likes to be out and about. Staff cannot always cater for this due to staff shortages.'

Failure to provide appropriate care that met people's needs and reflected their preferences was a breach of regulation 9 of the Health and Social Care Act 2008.

Care plans had been developed where needs had been identified through the assessment process. These were personalised and recorded people's preferences about their support as well as the care they needed. Care plans provided guidance for staff about how people's care should be delivered and there was evidence they were effective in ensuring people's personal care and health needs were met. For example one person's epilepsy was well-managed by the measures detailed in their care plan. Other people had needs related to

their diet and nutrition which were well-managed according to the guidance contained in their plans. People's support plans were kept under review to ensure they were responsive to any changes in need. For example, one person had experienced increasingly disturbed sleep patterns in recent months. The person's needs had been reviewed in February 2018 and the provider had applied for funding from the local authority for additional staff to support the person. Although the person had staff support to keep them safe, the additional staffing resources that had been arranged had not resulted in them accessing activities, which had been identified in their care plan as important to them.

There were appropriate procedures for managing complaints. The provider had a written complaints procedure that was available in an accessible format. This was displayed in the bungalows and the relatives we spoke with confirmed they knew how to complain if they needed to. They told us that any concerns they had registered in the past had been listened to and acted upon by the provider. Checks on the management of any complaints received were included in the provider's quality monitoring audits.

The provider had established people's preferences about their end of life care to ensure their wishes would be respected should they become seriously ill. The provider's PIR stated, 'Service users have an end of life plan, which has been drawn up with both the service users and their families wherever possible, this ensures cultural, religious and traditional needs are respected.' We saw evidence to confirm this statement in people's support plans. The PIR also set out how staff had supported people at the service and their relatives at difficult times. The PIR stated, 'Teams are supportive and ensure that families are given time and respect during end of life care for their loved ones. We have received many compliments on how we have supported people in a dignified manner during difficult times. Teams have also demonstrated that they have supported service users with empathy when sharing news on someone's passing.'

Is the service well-led?

Our findings

Since the previous registered manager had left their post in February 2018 the provider's regional manager and a cluster manager had provided management support for the service. The cluster manager travelled to the service during our inspection to provide any information we requested and to hear feedback about the visit. A new service manager had been appointed and was due to start work shortly after our visit. The provider's cluster manager told us the new manager would apply for registration with CQC. One of the relatives we spoke with after our visit had met the new manager when they visited their family member. The relative said of the new manager, "I am quite impressed. He is doing all the right things. You see him there, going round all the bungalows. He is very hands on."

Relatives told us their communication with the previous registered manager had been good. They said the previous registered manager had always been willing to discuss their family member's needs if they wished. Staff told us the previous registered manager had provided effective support to the staff team. One member of staff said, "With [previous registered manager] the support was there. She was always available when you had a problem." Relatives told us they had sufficient opportunities to give their views about the service and the support their family members received. One relative told us, "There is ample opportunity to raise concerns if we had any." People, relatives and other stakeholders had opportunities to give their views about the service. The provider carried out an annual survey of people, relatives and other stakeholders such as professionals with an involvement in people's care.

Relatives told us they had raised their concerns about the high use of agency staff with the provider's regional manager. They said the regional manager had acknowledged their concerns about how this issue affected their family members' care and had told them of the plans in place to address it. One relative told us, "She has started to address it. She said she would try and do something about it and she has." The relative said the regional manager had already brought in some additional staff able to offer experience and improve the consistency of support people received. The relative told us, "The ones she has recruited are experienced. They seem very good."

Team meetings took place at which staff were able to give their views. We saw that the agenda for team meetings included whistle-blowing, safeguarding and any restrictive practices. Team meetings were also used to discuss the provider's values, such as promoting dignity in people's care and ensuring people were valued as individuals. The minutes of previous team meetings demonstrated that staff had expressed frustration with the staffing situation. In December staff had expressed concerns about, 'Staff shortage – staff being moved around bungalows too much.' The minutes recorded that, 'Staff have worked hard to ensure that all objectives are met even with having an increase in agency staff' although also noted that, 'Low levels of [permanent] staff and 'correct staff' proves difficult to ensuring all objectives are met professionally and promptly.' The action plan submitted by the regional manager included measures to improve morale amongst the team and the support provided to staff. The plan included team meetings to be attended by the regional manager to listen to staff concerns and communicate the plans in place to address permanent staff shortages.

The Health and Social Care Act 2008 regulations include a responsibility on registered providers to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service and others, such as staff, who may be at risk. We have rated this domain 'Requires improvement' as, at the time of our inspection, the provider had not taken sufficient action to address the concerns about staffing and the subsequent negative effects on people living at the home.

Staff worked well in partnership with other agencies to ensure people received the care and support they needed. The staff team had established close links with the community learning disability team to support some people. For example people's care passports had been developed with input from a learning disability liaison nurse to ensure they contained appropriate professional advice. One person had been referred to a neurology consultant as they had experienced increasingly disturbed sleep patterns. We saw evidence in people's care plans that further visits with healthcare professionals were scheduled for people who had ongoing healthcare conditions.

The provider had a quality monitoring system that included regular audits of key areas of the service, such as medicines, infection control, complaints and any safeguarding referrals. Checks were also made to ensure people were receiving safe care. For example, risk assessments relating to choking were audited to check they were up to date. Where shortfalls were identified, action was taken to address them. For example, one audit had identified that risk assessments in relation to pressure care were out of date. We saw that the audit record had been updated to show that this had been addressed. The provider knew which events should be notified to CQC and had informed the Commission and other relevant agencies about notifiable events when necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to provide appropriate care that met people's needs and reflected their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.